LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV MEETING MINUTES
October 9, 2008

MEMBERS PRESENT	MEMBERS PRESENT, cont.	PUBLIC	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	James Skinner	Margo Edwards	Elisco Avalos
Anthony Braswell, *Co-Chair*	Robert Sotomayor	Shawn Griffin	Kyle Baker
Al Ballesteros		Richard Iniquez	Angela Boger
Anthony Bongiorno		Miki Jackson	Maxine Franklin
Carrie Broadus	**MEMBERS ABSENT**	Victor McKamie	Michael Green
Nettie DeAugustine	Mario Chavez	Richard Martinez	Mary Orticke
Whitney Engeran-Cordova	Eric Daar	Rich Mathias	Rakmi Sinma
Douglas Frye	Peg Taylor	Melissa Nuestro	Shobita Rajagopalan
David Giugni	Chris Villa	Trip Oldfield	Jacqueline Rurangirwa
Terry Goddard	Kathy Watt	Jenny O'Malley	Carlos Vega-Matos
Jeffrey Goodman	Fariba Younai	Herbith Osaño	Juhua Wu
Joanne Granai		Tammy Omoto-Frias	Dave Young
Richard Hamilton		Tania Trillo	
Michael Johnson		Maribel Ulloa	
Lee Kochems		Cynthia Zapata	**COMMISSION STAFF/CONSULTANTS**
Brad Land			
Ted Liso			Carolyn Echols-Watson
Anna Long		**SPN COORDINATORS**	Kay Grinnell
Manuel Negrete		*(Non-Commission Members)*	Dawn McClendon
Ruel Nolledo		Teresa Ayala-Castillo	Jane Nachazel
Quentin O'Brien		Tamara Charles	Glenda Pinney
Everardo Orozco		Lisa Fisher	Doris Reed
Dean Page			James Stewart
Angélica Palmeros			Craig Vincent-Jones
Mario Pérez			Nicole Werner
Natalie Sanchez			Donna Yutzy

1. **CALL TO ORDER**: Mr. Braswell called the meeting to order at 9:10 am.
   - **A. Roll Call (Present)**: Bailey, Ballesteros, Bongiorno, Braswell, Frye, Giugni, Goddard, Goodman, Granai, Johnson, Land, Long, Negrete, Nolledo, O'Brien, Orozco, Page, Palmeros, Pérez, Sanchez, Skinner, Sotomayor

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order, as amended ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:

MOTION #2: Approve the minutes from the August 14, 2008 Commission on HIV meeting ***(Passed by Consensus)***.

4. **CONSENT CALENDAR**:
MOTION #3: Approve the Consent Calendar, with Motion #4 removed for a presentation ***(Passed by Consensus)***.

5. **PARLIAMENTARY TRAINING**: Mr. Stewart reported the first 30-minute briefings on standard parliamentary procedures had been provided preceding the meeting. The next briefing will be prior to the December meeting.

6. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

7. **COMMISSION COMMENT, NON-AGENDIZED**: Mr. Goodman reported a lawsuit was filed against Western Dental for refusal of service due to HIV status. He is the lead plaintiff in the multi-plaintiff suit. It has received good publicity to date.

8. **PUBLIC/COMMISSION COMMENT FOLLOW-UP**: There were no items to be followed-up.

9. **STANDING COMMITTEE REPORTS**:

A. Joint Public Policy (JPP) Committee:

1. ***State Budget***: The item was discussed under the State Office of AIDS (OA) Report.
2. ***County's State Legislative Agenda***: Mr. Vincent-Jones reported that the Commission had recommended that two items for inclusion on the County's State Legislative agenda—support for enhanced consumer protection for pharmaceutical customers with chronic diseases, and opposition to "disease status" discrimination—both of which were approved by the Board.
3. ***Public Policy Docket***: The updated docket was in the packet.
4. ***SB 1184: CD4 Reporting***: With passage of SB 1184, the state's HIV reporting system is now complete and as comprehensive as any in the country.
5. ***Condoms in the Adult Film Industry (AFI)***: Mr. Engeran-Cordova reported a successful hearing with informed questions from the Committee. Over 40 people attended and testimony was heard from the Department of Public Health, Cal-OSHA, and several AFI performers. A video was made and a transcript is being prepared.

B. Standards of Care (SOC) Committee:

1. ***Medical Care Coordination (MCC)***:
   a. National Time for Change:
      - Mr. Vincent-Jones noted the MCC Framework was approved in November 2007. The SOC then began work on the standard and developing supportive information.
      - Ms. Yutzy presented at the All Grantees Meeting on the MCC work she has been doing in Oregon. She has also worked with other jurisdictions across the country, and was able to provide a national overview of the situation. She complimented the Commission's work, noting that jurisdictions are following Los Angeles' leads.
      - Ms. Yutzy reported that the financing system in 2001 was showing distress as people lived longer with better treatments and new infections added to the population. Improved health also meant fewer people qualified for Medicaid disability. Other Medicaid cutbacks followed as drug costs and co-morbidities needing health care and support increased. She noted geography determines services even for the poor, e.g., eligibility varies from 126% to 539% of the Federal Poverty Level (FPL), as does access to ADAP.
      - Congress asked the Institute of Medicine (IOM) to investigate the issue in 2001. Reports were issued on prevention in 2001, planning and assessment in 2003, and care financing and delivery in 2004.
      - There were four key findings. HIV/AIDS remained a public health issue best treated separately. Access to HAART was critical. Adherence to it delivered best results and prevention of drug resistance. Many PWH/A were not in care, including those in early stages. Centers of Excellence were also recommended.
      - HRSA responded in 2005 with revisions that required core services for the first time, linked supportive services to maintenance of primary medical care, and required identification of unmet need.
      - Themes developed that emphasized a standardized set of minimum, quality, data-driven, integrated services; outreach to and integration of people into services based on standardized eligibility requirements; and funding based on HIV-reporting formulas. Building on the latter, the most recent Ryan White legislation permits unused funds from one jurisdiction to be shifted to a jurisdiction not meeting its needs, e.g., prescription waiting list.
      - Ms. Yutzy anticipates mandates will move toward uniform eligibility and core services with co-payments above minimum standards, funding based on meeting core services, coordination of funding streams, fully integrated services including prevention and co-morbidities, and comprehensive quality standards already being issued.

- Principles guiding the 2006 Ryan White Reauthorization focused on serving the neediest first, which is expected to eventually require some form of acuity measure; services which save and extend lives with an emphasis on core services and the 75%/25% funding mandate; and increasing prevention, accountability, and flexibility.
- Ms. Yutzy emphasized managing change requires coordination with key stakeholders on constant improvement aimed toward a defined goal with testing, training, and implementation time built into transitions. It is critical to champion, document, and measure change while managing expectations and trusting the process.
- Judicious empowerment requires revision of job descriptions to define and pay for work that uses people's skills while maintaining responsibility and leadership, and challenging traditional practices and staffing.
- Limited time, resources, and decision-making authority present obstacles. Communication and motivation is especially challenging due to the range of knowledge, experience, and competence of stakeholders.
- Traditionally, the federal government has not been proactive in identifying and explaining upcoming changes so it is necessary to be alert to and seek information, e.g., on implications of IOM reports.
- The federal government is reviewing case management best practices, e.g., in hospitals, managed care, mental health, and substance abuse systems. Key components are evidence-based activities, case management teams, co-location and coordination of case managers and physicians, and telephonic care coordinators. Risk assessment tools along with cost, outcome, and program monitoring electronic tracking systems offer support.
- Oregon began to redesign their system in 2006 to address changing consumer needs in light of changing guidelines. They defined a Medical Case Management model with RN case managers via a process that mined data and incorporated stakeholder input to develop a transition plan with a multi-disciplinary transition team.
- Key aspects of their transition were to invite participation of experts from outside the EMA and to ensure a strong communication plan with defined talking points on the transition. One-third of participants on the transition team are consumers with others from the statewide coalition and the Portland Planning Council.
- Oregon lacked capacity to make the desired change, so initiated capacity building grants while developing a pilot program that will begin in 2009. Providers are already beginning to improve programs on their own.
- Mr. Pérez asked about management of the increasing number of PWH/A with co-morbidities like diabetes. Ms. Yutzy noted Medi-Cal/Medicare now provide 85% of national HIV/AIDS care. That points toward helping clients access benefits, e.g., in Massachusetts PWH/A who meet income requirements are eligible for Medi-Cal. Other possibilities include expanding the Major Risk Insurance Pool, including drugs like those for diabetes under ADAP, and attention to HOPWA. Such approaches allow Ryan White to function as supplemental funds.
- Mr. Iniquez said Health Services is considering full case management of the HIV/AIDS disease process.
- Mr. Braswell asked how to manage long-term in light of changing politics and decreasing resources. Ms. Yutzy recommended a standing transition team to keep ahead of the curve. She recounted a recent conversation with HRSA in which they expressed hope that major jurisdictions provide them with successful models to define medical case management. They are watching Los Angeles, in particular.

b. <u>Financial Model/Simulation:</u>

- Mr. Vincent-Jones noted the model was presented with random data the prior month to the Commission and Service Provider Networks (SPNs). The model had been refined and populated with the best available data.
- The model is designed to review different funding scenarios rather than provide specific answers. It is not a rate study nor operational assessment, so judgments can and have been made about which cost factors to include.
- Data was mostly collected from OAPP and from providers representing about 50% of case management clients.
- Core data points chosen for the basic model were: number of patients receiving case management (CM) and/or medical outpatient (MO), number of service units, allocations/expenditures, cost per service unit, acuity, and the scenarios. The two primary cost drivers chosen are: weighted average service unit and cost per service unit.
- There are 17,781 clients in the Ryan White Part A and B services funded through OAPP. Provider estimates were used to develop data for those receiving medical and/or case management care through non-Ryan White-funded services or who were not receiving one or both services.
- The cost per service unit (hour) was based on actual allocations, services, and the 10% administrative cost, but not the one month of MAI funds this fiscal year. The weighted average of medical and psychosocial service units was $51, but $100 was chosen as the core data point in lieu of suggestions that MCC units may cost more though providers already report significant coordination. Comparative data sets use $51 and $75.
- Acuity levels are defined differently among providers, so visit frequency was chosen to identify the basic five levels. Levels skew to high and medium with 70% of medical and 80% of psychosocial CM at those levels based on provider data. OAPP data revealed a more even distribution of acuity, but using the higher figures continues a conservative theme in data choices and may also reflect the patient population.
- The core weighted average of service units chosen is a generous 11.6 but, as with the unit cost, comparative sets were based on 8.8 and 18 even though the latter is four times the MO standard.

- Crisis acuity levels were based on providers who identified the percentage of their clients in crisis during a year.
- Providers were also asked to evaluate the variance in effort between a phone and in-person visit; although the phone visit was 59% of the effort of a visit (based on weighted averages of provider feedback), it was found not to be a significant cost driver.
- Modeling for economies of scale depends on decisions not yet made like reimbursement levels, staffing, and case loads. Even so, some concepts were reviewed, such as phone-based services for self-managed clients, reducing the number of programs which could result in savings of staff costs, and centralized intake.
- State Medi-Cal AIDS Waiver and CMP programs were identified as possible alternate funding sources. Aside from state budget issues, significant work would be needed to develop consistency between the services respecting both statewide concerns and the local need for flexibility.
- Ms. Grinnell demonstrated the interactivity of the model in real time. The core twelve color-coordinated cells reflecting the patient's MO status and CM status. Adding acuity results in 60 cells.
- No model has perfect data though it improves over time. Experimenting with data points reveals which most affect the outcome, so they can be targeted for additional research.
- Three scenarios were detailed: patients receiving CM, but not MO; MO, but not CM; and neither. Impact summaries reflect the cost to address each population. Key data points can be adjusted and applied to each scenario.
- Simulations can be run as graphs of patient distribution, e.g., weighted average service units of 11.6 with a $100 cost per service unit can be run with a standard deviation of $20 that predicts 65% of patients will fall between $80 and $120. The simulation can run the model against data, e.g., applying the lognormal distribution yields an 84% probability that added cost will be $2 million or less. The probability percentage can also be adjusted.
- Mr. Vincent-Jones noted the financial simulation reflects that MCC care efficiencies, redundancy elimination, and the shift to a unit cost measure can result in lower costs even when accounting for low acuity patients that some feel may not be receiving services now. The MCC model has also been shown to improve care.
- The model can be used to help in determining allocations for the other service categories by identifying areas in need of additional resources, e.g., Benefits Specialty may need more support overall as well as training.

c. Standard of Care:

- Mr. Vincent-Jones reported three minor changes generated by public comment. The first adds "accessibility" to treatment planning for medications. The second makes re-assessment an explicit part of case worker meetings. Finally, case closure sign-off was changed from one to both care managers to mirror intake.
- Mr. Engeran-Cordova asked about transition steps. Mr. Pérez noted the joint statement and timeline. OAPP is committed to collaboration with the understanding that implementation may require changes, e.g., due to funding changes.
- Mr. Vincent-Jones noted the timeline posits initiation in March 2010. A steering committee will include Commissioners, OAPP staff, and other interested parties. Writing a service description is the next step.
- Mr. Pérez said the system was migrating to a medical model and must evolve to meet a growing population's needs. While fewer people now receive CM than would under MCC, many MO providers assert they already provide some.
- He added OAPP had start discussions with the state and providers to rethink subjects like Home-Based CM. Stakeholders need to be aware that some services are likely to change or be cut as care becomes more medically based and more cost effectively delivered, e.g., with more phone appointments.
- He continued that the MCC model relies on staff with more specific skill sets, so capacity building will be key.
- Mr. Vincent-Jones said the P&P will address implementation with the next priorities- and allocation-setting cycle in April or May. Capacity building and Benefits Specialty are likely to need funds via redirection or increases. The financial model may suggest funds through cost savings and/or due to improved patient health.
- He felt data points used were fair and leaned toward the conservative, but will be refined with use. Since Ryan White is funding of last resort, price points may not reflect services offered privately, which are not covered.
- Mr. Engeran-Cordova felt MCC would reduce multiple case managers and increase provider communication.
- Mr. Land felt capacity funding could be identified by reducing redundancy, but P&P should discuss modeling and procurement for the entire system with OAPP to inform its decisions.
- Mr. Nolledo complimented the presentations, but asked to postpone the vote due to the complexity of the material.

MOTION #3A ***(Nolledo/Liso)***: Postpone the vote on the Medical Care Coordination standard of care until the December meeting ***(Failed: 2 Ayes; 21 Opposed; 1 Abstention)***.

MOTION #4: Approve the Medical Care Coordination standard of care, as presented ***(Passed: 21 Ayes; 2 Opposed; 1 Abstention)***.

d. Implementation Next Steps: Implementation was incorporated in the previous discussion.

2. ***Grievance Policy and Procedure***: The item was postponed.
3. ***Language Services Standard of Care***: Public comment was re-opened until November 5th because an older version of the standard was accidentally issued previously. All comments should be directed to Ms. Reed.
4. ***ADAP Enrollment Standard of Care***: Public comment was opened for this new standard until November 5th. It was broken out from MO to be consistent with the rate study.
5. ***Medical Outpatient/Specialty Standard of Care***: Public comment was opened for this newly merged standard until November 5th.
6. ***Local Pharmacy Program/Drug Reimbursement (LPP/DR) Standard of Care***: Public comment was opened for this new standard until November 5th. It was broken out from MO because HRSA is requiring separate consideration.
7. ***Hospice Standard of Care***:
   MOTION #5: Approve the Hospice standard of care, as presented ***(Passed as part of the Consent Calendar)***.

C. Priorities & Planning (P&P) Committee:

1. ***FY 2009 P- and A- Setting Process***: Mr. Goodman noted the memorandum in the packet summarizing the process.
2. ***Data Summit***: Mr. Pérez said the November 21st summit would review available data to inform community dialogue.
3. ***OAPP Financial Reports***: Reports as of July 31st were in the packet. Dave Young would report in December.
4. ***Comprehensive Care Plan***: The work group has been meeting and will present their draft at the annual meeting.

D. Operations Committee:

1. ***Consumer Caucus***:
   - Mr. Johnson, newly elected Co-Chair, reported on the SPA #2 "Meet the Grantee" meeting in Van Nuys. About 40 people attended, including a significant number of Spanish-speaking consumers. Oral Health and Transportation were highlighted concerns. Issues raised continue to be added to a follow-up matrix being tracked with OAPP.
   - Ms. Baumbauer, previous Co-Chair, has retired from the Commission to accept a Kaiser Permanente position.

11. CO-CHAIRS' REPORT:

A. Annual Meeting: A flyer on the November 13th meeting at Luminarias Restaurant was in the packet.

B. PC Letter of Assurance: The annual letter required by HRSA in support of the Part A application was in the packet.

12. EXECUTIVE DIRECTOR'S REPORT: Mr. Vincent-Jones noted MOU discussions have been completed. He will complete editing the document once the Comprehensive Care Plan has been submitted.

A. Benefits Consulting:

- Mr. Vincent-Jones reported the Commission and OAPP have jointly hired Julie Cross as a benefits consultant. She will continue to consult for the state which is expected to improve County-State communication.
- Ms. Cross is the state's top expert in the area with special knowledge regarding HIV issues. The decision to hire was based on the increasing importance of benefits for consumers and the complexity of the issues.
- The Scope of Work emphasized three areas: developing training especially for medical care coordination, policy work especially from the Commission viewpoint, and advocacy for both providers and consumers.

B. Medical Transportation: Mr. Vincent-Jones noted that HRSA will not allow Medical Transportation to be used for support services, as well .

13. STATE OFFICE OF AIDS REPORT:

- Mr. Iniquez reported that the state government travel and expenditure economies locked down during the budget process had been relaxed, but not eliminated. Staff had been authorized to again visit planning councils though travel will be monitored.
- Statewide, there are 41,155 code-based and 31,396 name-based cases as of September 30th. Of the 15,304 County code-based cases, 1.397 are from Long Beach, and 130 from Pasadena. Of the 11,323 name-based cases, 1,229 are from Long Beach, and 94 from Pasadena.
- Dr. Frye noted the deadline to collect name-based cases was December 31st. He was pleased the state identified more than the 11,253 cases HIV Epidemiology had counted. There were still about 1,600 code-based cases with named reports that had not been converted to name-based cases. About 700 of those were from Kaiser which has not cooperated, but HRSA might allow those cases to be matched automatically. He expected about 13,000 cases by year's end which was less than hoped, but still good. CD4 reporting resulted in an additional 1,600 new reported AIDS cases this year.
- Mr. Iniquez noted HIV-related bills recently signed by the Governor:
  ⇨ AB 1894 makes California the first state to require health insurance and service plans cover HIV testing regardless of its relation to a primary diagnosis.

- ⇨ AB 2737 allows court-ordered testing if a peace officer, fire fighter, or emergency medical personnel is exposed to an arrestee's blood or bodily fluids. A licensed health care provider must seek voluntary consent before applying to a court.
- ⇨ SB 2899 permits low-risk individuals previously tested to receive less intensive education.
- ⇨ SB 1184 was co-sponsored by the County, San Francisco AIDS Foundation and APLA. Originally designed to ensure CD4 reporting, it also corrected some sperm-washing technology language passed the prior year. Mr. Baker, OAPP, is working with the state to ensure laboratories report CD4s. Dr. Frye is also contacting laboratories, though most seem informed.

- Mr. Iniquez reported that the state budget increased OA funding from $427.9 million to $462.5 million. Care programs and ADAP remained stable. The Therapeutic Monitoring Program (TMP) was reduced, but then infused with ADAP rebate funds for a net increase. Education and Prevention did not receive the augmentation of $5.6 million it had the three prior years, but was increased by $1.3 million from the Department of Mental Health which will cover some of their services.
- Mr. Nolledo added that the AIDS Counseling Program and the Crystal Meth Prevention Program were cut.
- All invoices can now be processed. The Governor, however, cut temporary, part-time, and retired annuitants. Many staff in the accounting and claims payment areas were in those categories and the remaining staff face a backlog from the freeze.
- Mr. Iniquez added that OA had a staff person dedicated to corrections who was working on the health care issue there.
- Changes in other areas of the budget will also affect OA programs and PWH/A. In particular, in November the state will stop paying the Medi-Cal Part B share-of-cost premium for the 57,000 seniors and disabled with a Medi-Cal share-of cost above $500. This has been included in the Social Security retirement or SSDI check for those who qualified for both Medi-Cal and Medicare. OA is just beginning to address this, but some may not be able to cover the $96.40 premium and will lose coverage. Dr.. Roland and Stan Rosenstein, Director, Medi-Cal, are preparing information for counties, contractors, and local partners. Mr. Vincent-Jones said Ryan White cannot supplement Medi-Cal, but Ms. Cross was pursuing options.
- Mr. Iniquez read a text from Ms. Cross noting many affected clients are unaware the State has been paying the premiums. This may prompt clients to cancel coverage without understanding consequences like the time it takes to re-enroll.
- Mr. Ballesteros felt the state had the responsibility to inform clients and to provide planning councils more information. Ms. DeAugustine noted providers needed specifics to advise clients. Mr. Land added previous state letters were confusing.
- Mr. O'Brien noted Part B was optional. Those who disenroll will likely increase stress on Ryan White services. He added only a lawsuit was preventing the 10% Medi-Cal provider cut threatening clients' care. More advocacy was imperative.
- Mr. Land suggested revising Ryan White eligibility criteria to increase access to services like food to offset other cuts.
- Mr. Goodman recommended seeking a way to cover insurance premiums in general to support Ryan White viability.
- ➲ Mr. Iniquez will check with Michelle Roland to ensure laboratories statewide were implementing SB 1184 CD4 reporting.
- ➲ Mr. Iniquez will also check to ensure the Medi-Cal cut will not be retroactive to the beginning of the budget year.
- ➲ It was agreed Ms. Cross, the Commission, and OAPP would promptly develop a Medicare Part B strategy and then inform clients.

14. **OFFICE OF AIDS PROGRAMS AND POLICY REPORT**:

A. HIV and Aging: The presentation was postponed.

B. FY 2009 Part A Application: The application was submitted. A copy was in the packet.

C. Medicare Part D Gap Assistance:

- Ms. Ulloa, Aid for AIDS (AFA) Client Services Coordinator, reported that five clients had been evaluated by the program since August. Four, however, were already in catastrophic threshold and paying their co-pays, so only one was being served.
- Outreach continues in the County through OAPP and AFA, including their contacts with HOPWA and a presentation for the Entertainment Assistance Cooperative that works with organizations like SAG and AFTRA.
- The program runs through December 31st. Mr. Goodman noted many people fall into the gap in February or March, but Mr. Pérez noted the program was only designed to temporarily bridge the gap to the end of the Medicare Part D cycle.
- Mr. Vincent-Jones pointed out that Ryan White had to be funding of last resort. People are apparently finding ways to get their medications. How they are doing that and the broader legislative issue are still to be addressed.
- Mr. Johnson said the Consumer Caucus will discuss the issue at its meetings November 3rd and December 2nd, 12:30 pm.

D. Miscellaneous:

- Mr. Pérez welcomed Richard Martinez the Chief Executive Office (CEO) Budget Analyst for OAPP. Mr. Martinez then introduced Tammy Omoto-Frias, Budget Analyst for Alcohol and Drug Programs and Children's Medical Services; and Cynthia Zapata, Budget Analyst for the Antelope Valley Rehab Center.
- He noted that the anticipated state education and prevention reduction of $400,000 was averted which helped the County portfolio. The Therapeutic Monitoring Program (TMP) base of $4 million was also preserved and additional dollars allocated.

- Mr. O'Brien asked when more genotype/phenotype vouchers would be available. Mr. Pérez said the OA usually identified the size of the first of two six-month allocations in July. The County uses somewhat more than other jurisdictions, exhausting its first allocation in November, then supports the program until receiving its January allocation. Those are first used to make up any shortfall, then run out again in March or April. At that point OAPP reviews funding options. The state has provided additional vouchers for the last few years and, with TMP funding this year, will again be providing new vouchers shortly.
- Ms. Orticke is also reviewing genotype, phenotype, and viral load voucher use at the 22 providers and 33 sites. Some 20% to 25% are not being turned into laboratories or returned to OAPP. Damaged vouchers can be exchanged by OAPP for new ones, but discarded vouchers are invalidated. A database system is being developed to track voucher use.
- Mr. Pérez reminded all that the National Latino AIDS Awareness Day (NLAAD) would be October 15th. There would be an event hosted by OAPP and the NLAAD on October 14th, at 8:00 am, at the California Endowment.

15. **HIV EPIDEMIOLOGY PROGRAM REPORT**:

- Dr. Frye noted the state continues to use cumulative, rather than living, AIDS cases. As of August there are 11,253 living non-AIDS HIV name-based cases in the County.
- He noted that de-duplication efforts resulted in the decrease in numbers from August to September. This is part of the transition plan required by the CDC.
- He expected to report over 13,000 cases for the year despite cases not yet released by Kaiser Permanente. That is consistent with the County's usual one-third of California cases. There are also 1,600 coded cases being matched with named laboratory reports including 690 from Kaiser. Approval has been requested from the CDC for HIV Epi staff to match the Kaiser cases.
- No incidence estimate was released in 2008 as it was felt 2006 data was not reliable due to the transition to name-based reporting. A 2007 estimate of new County cases will be released in January 2009 and will be included in national data.
- The County and the San Francisco EMA have sent a joint letter to Michelle Roland requesting revisions in regulations to increase the ability to identify new cases.
- A new CD4 database has been created to receive the data generated by the new legislation. Another 80,000 CD4 reports are expected per year. Many will match existing cases while others will enhance AIDS reporting accuracy.

16. PUBLIC HEALTH/HEALTH CARE AGENCY REPORTS: There were no reports.

17. PREVENTION PLANNING COMMITTEE (PPC) REPORT:

- Mr. Giugni reported that last week's meeting included a colloquia on intimate partner violence and depression among ingestion drug users as transmission co-factors. JWCH, the City of Pasadena, and In The Meantime also gave presentations.
- Kevin Farrell provided an update on state prevention funding. The elimination of the next phase of the meth campaign was of particular concern since its first year had been successful in drawing more people into treatment.
- The PPC also approved new policies and procedures for the body to go green.

18. SPA/DISTRICT REPORTS:

- **SPA #1:** Ms. Granai reported the October 8th meeting included Department of Public Health (DPH) MRSA training and review of the SPA's "Meet the Grantee" meeting. There will be an AIDS Walk October 19th. The next meeting will be November 12th.
- **SPA #2:** Ms. Sanchez reported September 25th meeting presentations on a court program which permits a one-time dismissal of qualifying offenses and a mentorship program for PWH/A living at Camp Laurel. The next meeting will be October 23rd. She also thanked Mr. Orozco for his work in making their "Meet the Grantee" meeting a success.
- **SPA #3:** Mr. Land reported for Mr. Chavez that agencies had requested more information on technical support. OAPP will provide information for the next meeting. The East Valley Community Health Clinic and AIDS Service Center in Pasadena will be hosting a consumer town hall meeting on November 5th.
- **SPA #4:** There was no report.
- **SPA #5:** There was no report.
- **SPA #6:** Ms. Charles reported there was a provider community mobilization forum with OAPP on September 2nd. There was a DPH presentation on the National HIV Behavioral Surveillance at the September 9th meeting. Jackie Jones, Pfizer, will provide training on Hepatitis C at the next meeting on October 14th
- **SPA #7:** There was no report.
- **SPA #8:** Ms. Ayala-Castillo reported the SPN Coordinators have started a working group to develop consumer leadership training. An early report will be presented at the October 10th integration meeting with OAPP with a report to the Commission in the near future. The next SPN meeting will be October 15th.

19. TASK FORCE REPORTS:

A. Commission Task Forces: There were no reports.

B. Community Task Forces: There were no reports.

20. **COMMISSION COMMENT**: There were no additional comments.

21. ANNOUNCEMENTS:

- Mr. Hamilton announced a community organizing meeting for the February 7th National Black HIV/AIDS Awareness Day. The meeting will be at the Asian American Drug Program, October 10th, 2:00 pm. He encouraged all agencies, including those who do not traditionally service the African-American community, to attend.
- Mr. Nolledo announced the Southern California HIV Action Coalition (SCHAC) will hold its annual planning meeting on October 25th. The meeting will focus on state budget and legislative priorities for the year.
- Mr. O'Brien announced information for the No on Proposition 8 campaign was available at www.noonprop8.com. The proposition would include language to define marriage as between a man and a woman in the California Constitution.

22. ADJOURNMENT: Mr. Braswell adjourned the meeting at 1:40 pm. in honor of Diana Baumbauer's service to the Commission and in memory of Daniel Garcia, volunteer of 20 years with Life Group and Positive Living, who passed away in September.

A. Roll Call (**Present)**: Bailey, Ballesteros, Bongiorno, Braswell, DeAugustine, Giugni, Granai, Hamilton, Kochems, Land, Liso, Long, Negrete, Nolledo, O'Brien, Orozco, Page, Palmeros, Pérez, Sanchez, Skinner, Sotomayor.

MOTION AND VOTING SUMMARY		
MOTION #1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION #2: Approve the minutes from the August 14, 2008 Commission on HIV meeting.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3: Approve the Consent Calendar.	***Passed by Consensus***	**MOTION PASSED**
MOTION #3A *(Nolledo/Liso)*: Postpone the vote on the Medical Care Coordination standard of care until the December meeting.	***Ayes:*** Liso, Nolledo ***Opposed:*** Bailey, Ballesteros, Braswell, DeAugustine, Engeran-Cordova, Giugni, Goddard, Goodman, Hamilton, Johnson, Kochems, Land, Long, Negrete, O'Brien, Orozco, Page, Palmeros, Sanchez, Skinner, Sotomayor ***Abstentions:*** Granai	**MOTION FAILED** **Ayes**: 2 **Opposed**: 21 **Abstention**: 1
MOTION #4: Approve the Medical Care Coordination standard of care, as presented.	***Ayes:*** Bailey, Ballesteros, Braswell, DeAugustine, Engeran-Cordova, Giugni, Goddard, Goodman, Hamilton, Johnson, Kochems, Land, Long, Negrete, O'Brien, Orozco, Page, Palmeros, Sanchez, Skinner, Sotomayor ***Opposed:*** Liso, Nolledo ***Abstentions:*** Granai	**MOTION PASSED** **Ayes**: 21 **Opposed**: 2 **Abstention**: 1
MOTION #5: Approve the Hospice standard of Care, as presented.	***Passed as part of the Consent Calendar***	**MOTION PASSED**